CHAPTER 2

SOUTH CAROLINA'S MENTAL RETARDATION/RELATED DISABILITIES (MR/RD) WAIVER DOCUMENT

EFFECTIVE OCTOBER 1, 2004-SEPTEMBER 30, 2009

SECTION 1915 (c) WAIVER FORMAT

1. The State of **South Carolina** requests a Medicaid home and community-based services waiver under the authority of section 1915 (c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a. _____ Yes b. **X** No

   This waiver is requested for a period of (check one):

   b. **X** 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   b. **X** Intermediate care facility for mentally retarded or persons with related disabilities (ICF/MR)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   f. **X** mentally retarded and persons with related disabilities

4. A waiver of section 1902 (a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

   e. **X** Not applicable

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

   a. _____ Yes b. **X** No

7. A waiver of §1902 (a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

   a. ___ Yes b. ___ No c. **X** N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

   a. _X_ Yes b. ___ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

   a. ___ Yes b. _X_ No

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State request that the following home and community-based services, as described and defined in Appendix B-1 of this request, be included under this waiver:

   d. _X_ Personal care services

   e. _X_ Respite care

   f. _X_ Adult day health

   g. _X_ Habilitation

      _X_ Residential habilitation

      _X_ Day habilitation

      _X_ Prevocational services

      _X_ Supported employment services

   h. _X_ Environmental modifications

   k. _X_ Specialized medical equipment, Supplies and Assistive Technology

   n. _X_ Adult companion services

   s. _X_ Extended State Plan services (Check all that apply):

      _X_ Physical therapy services

      _X_ Occupational therapy services

      _X_ Prescribed drugs

_X_ Other Services (specify):

1. Speech-Language pathology
2. Audiology services
3. Adult Dental services
4. Adult Vision services

t. _X_ Other Services (specify):

1. Psychological services
2. Nursing services
3. Private Vehicle Modifications
4. Behavior Supports services

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services, which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (check all that apply):

a. _X_ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. _X_ Meals furnished as part of a program of adult day health services.

For the purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternative under the waiver; and

2. Given the choice of either institutional or home and community-based services

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures of the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller Generals, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502

a. **X** Yes b. ___ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ___ Yes b. **X** No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure that quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of **October 1, 2004** is requested.

20. The State contact person for this request is **Kara Lewis**, who can be reached by telephone at **(803) 898-2710**.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: Robert M. Kerr

Title: Director

Date: _____

APPENDIX A – ADMINISTRATION

LINE OF AUTORITY FOR WAIVER OPERATION

Check One:

_X_ The waiver will be operated by the South Carolina Department of Disabilities and Special Needs (SCDDSN), a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B – SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

d. _X_ Personal care services:

_X_ Assistance, either hands-on (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself, in the performance of IADLs or ADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist of delivering payments to a designated recipient on behalf of the client. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services. Using this revised definition, authorizations to providers will be made at two different payment levels. The higher level will be call Personal Care 2 and will be used when the majority of care is related to activities of daily living. The lower level, Personal Care 1, will be authorized when most of the needed care is for instrumental activities of daily living.

1. Services provided by family members (Check one):

   _X_ Payment will not be made for personal care services furnished by a member of the individual's family per State Medicaid policy.

2. Supervision of personal care providers will be furnished by (Check all that apply):

   _X_ A registered nurse or a licensed practical nurse, licensed to practice nursing in the State, when the service requires hands-on assistance with activities of daily living.

   _X_ Other (specify): High school diploma or equivalent required when the service requires no hands-on assistance with activities of daily living.

3. Frequency or intensity of supervision (Check one):

   _X_ Other (specify): As indicated in provider contracts.

4. Relationship to State plan services (check one):

_X_ Other service definition (specify): Personal care services provided under the approved State plan for individuals 21 years of age and younger, and provided under the waiver for individuals 21 years of age and older.

e. **_X_** Respite care:

_X_ Services provided to individuals unable to care for themselves; furnished on a short –term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence,

Respite care will be provided in the following location(s) (check all that apply):

_X_ Individual's home or place of residence

_X_ Foster home

_X_ Medicaid certified ICF/MR

_X_ Group home

_X_ Licensed respite care facility

_X_ Other community care residential facility approved by the State that is not a private residence (Specify type): Community Residential Care Facility

_X_ Licensed Nursing Facility

f. **_X_** Adult day health:

_X_ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. The State intends to limit services to individuals with medically complex conditions; or individuals who would not likely benefit from either day habilitation, prevocational habilitation, or supported employment services. Authorization of services will be based on the recipient's need for the service as identified and documented in the individual's plan of care. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care are not furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. **X** Yes 2. ___ No

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. **X** Habilitation:

X Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Residential habilitation: Residential habilitation services include the care, skills training and supervision provided to individuals in a non-institutional setting. The degree and type of care supervision, skills training and support of individuals will be based on the plan of care and the individual's needs. Services include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows Medicaid payment does not cover these components is attached to Appendix G.

X Day habilitation: Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation

services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

X Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-tasks oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

X When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

X Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waivers services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

The State will require prior institutionalization in a NF or ICF/MR before a recipient is eligible for expanded habilitation services (prevocational, educational and supported employment).

1. ___Yes 2. **X** No

With the exception of Supported Employment, transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. **X** Yes 2. ___ No

The State requests the authority to provide the following additional services, not specified in the stature. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental modifications:

X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require institutionalization. Home is defined as non-government subsidized living quarters, and modifications to any government-subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Such adaptations may include the installation

of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. **Adaptations that add square footage to the home are excluded from this benefit.** All services shall be provided in accordance with applicable State or local building codes. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the service coordinator/**early interventionist** based on the recipient's need as documented in the plan of care. Three bids for the modification are obtained by the service coordinator/**early interventionist** and submitted with documentation of the need. This information is reviewed by South Carolina Department of Disabilities and Special Needs (SCDDSN) staff for programmatic integrity and cost effectiveness. To ensure cost neutrality, the environmental modification service must be within the lifetime monetary cap of $7,500 per recipient, and the recipient's actual total expenditure for home and community based and other Medicaid services under the waiver will not exceed the cost of care in an ICF/MR. **The service coordinator/early interventionist will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the SC/EI will assist with transitioning the client into institutional placement.**

k. X Specialized Medical Equipment, Supplies and Assistive Technology:

X Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

n. **X** Adult Companion services:

X Non-medical care, supervision and socialization, provided to a functionally impaired adult individual. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care but may entail hands on assistance or training to the recipient in performing activities of daily living and independent living skills. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.

s. X Extended State Plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

X Physical therapy services

X Occupational therapy services

X Prescribed drugs: An additional two (2) prescribed drugs over the State plan limit will be allowed under the waiver

X Other State plan services (specify):

1. Speech-Language Pathology: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will not duplicate any services available to adults in the State plan.

2. Audiology services: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will not duplicate any services available to adults in the State plan.

3. Adult Dental services: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will no duplicate any services available to adults in the State plan.

4. Adult Vision services: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will not duplicate any services available to adults in the State plan.

t. X Other waiver services which are cost-effective and necessary to prevent institutionalization (specify):

1. Psychological Services: Services focused upon assessment of needs and counseling/therapy designed to address specific needs in areas such as cognitive and/or affective skills. These services include initial assessment for determining need for and appropriateness of psychological services, psychological testing, goal-oriented counseling/therapy focused on issues related to seriously inappropriate sexual behavior (e.g., those behaviors which could lead to criminal sexual misconduct).

2. Nursing Services: Continuous or intermittent care provided to the individual in accordance with the plan of care as deemed medically necessary by a physician. Services are provided by licensed nurses within the scope of the State's Nurse Practice Act. **To ensure cost-neutrality the maximum number of hours authorized for nursing services may not exceed the sub-acute hospital care rate. The Service Coordinator/Early Interventionist will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the Service Coordinator/Early Interventionist will assist with transitioning the client into institutional placement.**

3. Private Vehicle Modifications: Modifications to a privately owned vehicle used to transport the waiver recipient, and for any equipment needed by the recipient which makes the vehicle accessible to the recipient. Modification to any government- subsidized vehicle is not permitted. To ensure cost-neutrality, the private vehicle modification service must be within a monetary cap of **$7,500 per vehicle and a lifetime cap of 2 vehicles**. The approval process for vehicle modifications is initially determined by the Service Coordinator or Early Interventionist based on the recipient's needs as identified and documented in the plan of care, and the availability of a privately owned vehicle that would be used for transportation on a routine basis. The criterion used in assessing a recipient's need for this service are: 1) The parent or family member cannot transport the individual because the individual cannot get in or out of the vehicle; 2) The individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier. Bids for the service are obtained and submitted along with the documentation of the need to SCDDSN. Each request is reviewed programmatically and fiscally before approval is given. The approval process is the same for any privately owned vehicle modification, regardless of ownership.

4. Behavior Support Services: Services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key persons, collection of objective data; analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart illustrates the requirements for the provision of each service under the waiver. Licensor, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider Type	License	Certification	Other Standard
d. Personal care services	Personal care provider			Attachment 1-Minimum qualifications; Medicaid Enrolled Providers.
e. Respite care	Respite provider; Foster Home; Licensed Respite Care Facility; Medicaid certified ICF/MR; Group home; Community Residential Care Facility; Nursing Facility	Code of laws of SC, 1976 as amended: 44-20-170 through 44-10-1000; 44-20-10 et seq.,; 44-21-10 et seq., 44-7-110 et seq.; SCDHEC Regulation Number NF61-17		Attachment 2-Minimum qualifications; Medicaid Enrolled Providers
f. Adult day health	Adult day care provider	Code of Laws of SC, 1976 as amended: 44-7-260.		Medicaid Enrolled Providers
g. Habilitation	Residential habilitation provider; Day habilitation provider; Prevocational services provider; Supported employment services provider	Code of Laws of SC, 1976 as amended: 40-20-170 through 44-10-1000; 44-20-10 et seq.; and 44-21-10 et seq.; SC Licensing regulations: Mo. 61-103		Medicaid Enrolled Providers
h. Environmental modifications	Licensed Contractor	Code of Laws of SC, 1976 amended: 40-59-15 et. Seq.		Medicaid Enrolled Providers
k. Specialized medical equipment, supplies and Assistive technology	Durable Medicaid Equipment provider			Medicaid Enrolled Providers
n. Adult companion services	Adult Companion provider			Attachment 3-Minimum qualifications; Medicaid Enrolled Providers.

Service	Provider Type	License	Certification	Other Standard
s.1. Physical therapy services	Licensed Physical Therapist	Code of Laws of SC, 1976 as amended; 40-45-10 et seq.		Medicaid Enrolled Providers
s.2. Occupational therapy services	Licensed Occupational Therapist	Code of Laws of SC, 1976 as amended; 40-36-10 et seq.		Medicaid Enrolled Providers
s.3. Prescribed drugs	Licensed Pharmacist	Code of Laws of SC, 1976 as amended; 40-43-30 et seq.		Medicaid Enrolled Providers
s.4. Speech-Language Pathology	Licensed Speech Pathologist	Code of Laws of SC, 1976 as amended; 40-67-10 et seq.		Medicaid Enrolled Providers
s.5. Audiology services	Licensed Audiologist	Code of Laws of SC, 1976 as amended; 40-67-10 et seq.		Medicaid Enrolled Providers
s.6. Adult Dental services	Licensed Dentist, Board Certified Oral Surgeon, or Dental Hygienist	Code of Laws of SC; 1976 as amended; 40-15-70 et seq.		Medicaid Enrolled Providers
s.7. Adult Vision services	Licensed Optometrist, Ophthalmologist, or Optician	Code of Laws of SC, 1976 as amended; 40-37-10 et seq.; 40-38-10 et seq.; or 40-47-5 et seq.		Medicaid Enrolled Providers
t.1. Psychological services	Psychological services provider	Code of Laws of SC, 1976 as amended; 40-55-20 et seq.; 40-75-5 et seq.		Attachment 4-Minimum qualifications; Medicaid Enrolled Providers
t.2. Nursing Services	Licensed Practical Nurse or Registered Nurse	Code of Laws of SC, 1976 as amended; 40-33-10 et seq.		Medicaid Enrolled Providers
t.3. Private vehicle modifications	Private vehicle modification provider			Attachment 5-Minimum qualifications; Medicaid Enrolled Providers
t.4. Behavior support services	Behavior support provider			Attachment 6-Minimum qualifications Medicaid Enrolled Providers

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Minimum Qualifications: Personal Care

A Personal Care provider must:

- Be at least 18 years old;
- Have the ability to speak, read, and write English;
- Be capable of following a Plan of Care with minimal supervision;
- Have no record of abuse, neglect, crimes committed against other people or felonious convictions of any kind;
- Be free from communicable diseases;
- Possess a valid driver's license if driving is required as part of the job; and
- The caregiver must demonstrate competency by the successful completion of exams designed to measure knowledge in the areas of:

    1. Confidentiality, accountability and prevention of abuse and neglect;
    2. First aid;
    3. Fire safety/disaster preparedness;
    4. Understanding disabilities;
    5. Signs and symptoms of illness and seizure disorders.

    Caregivers may be considered competent in areas 3, 4, and 5 if the responsible party approves their competency without testing.

Minimum Qualifications: Respite Care

A Respite Caregiver must:

- Be at least 18 years old;
- Have the ability to speak, read, and write English;
- Be capable of aiding in the activities of daily living;
- Be capable of following a Plan of Care with minimal supervision;
- Have no record of abuse, neglect, crimes committed against other people or felonious convictions of any kind;
- Be free from communicable diseases;
- Possess a valid driver's license if driving is required as part of the job; and
- The caregiver must demonstrate competency by the successful completion of exams designed to measure knowledge in the areas of:

    1. Confidentiality, accountability and prevention of abuse and neglect;
    2. First aid;
    3. Fire safety/disaster preparedness;
    4. Understanding disabilities;
    5. Signs and symptoms of illness and seizure disorders.

    Caregivers may be considered competent in areas 3, 4, and 5 if the responsible party approves their competency without testing.

Minimum Qualifications: Adult companion Services

An Adult Companion Services provider must:

- Be at least 18 years old;
- Have the ability to speak, read, and write English;
- Be capable of aiding in the activities of daily living;
- Be capable of following a Plan of Care with minimal supervision;
- Have no record of abuse, neglect, crimes committed against other people or felonious convictions of any kind;
- Be free from communicable diseases;
- Possess a valid driver's license if driving is required as part of the job; and
- The caregiver must demonstrate competency by the successful completion of exams designed to measure knowledge in the areas of:

    1. Confidentiality, accountability and prevention of abuse and neglect;
    2. First aid;
    3. Fire safety/disaster preparedness;
    4. Understanding disabilities;
    5. Signs and symptoms of illness and seizure disorders.

    Caregivers may be considered competent in areas 3, 4, and 5 if the responsible party approves their competency without testing.

Minimum Qualifications: Psychological Services

Providers of Psychological Services must:

1. Hold a doctorate or master's degree in psychology, counseling, or social work from an institution of higher education fully accredited by a regional accrediting body; AND

2. Specify the area(s) of psychological services in which they seek approval to provide waiver reimbursed services (e.g., counseling/therapy; sex offender treatment); AND

3. Have at least one year of experience working with persons with mental retardation and related disabilities in the area of psychological services in which they seek approval to provide service. The specific area of professional competence will be documented in the Providers Pre-enrollment requirements and qualifications. All areas of competence must be supported by documented course work, professional training and supervised experience.

Minimum Qualifications: Private Vehicle Modification

Providers of Private Vehicle Modifications must be trained and certified in the installation and repair of the manufacturers equipment.

Minimum Qualifications: Behavior Support Services

A Behavior Support Services provider must:

1. Possess a bachelor's, master's or doctorate degree in psychology or a human services field from an institution of higher education fully accredited by a regional accrediting body and have successfully completed course work and/or supervised training or employment that yields competence in the areas of basic behavior, analytic principles and application of behavior analytic principles and methods in applied settings for persons with mental retardation and related disabilities;

2. Have at least one year of experience in behavioral assessment and design, and implementation of behavior support plans for persons with mental retardation and related disabilities;

3. Meet the criteria for demonstration of knowledge, skills and abilities for Behavior Support Services.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

X A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C – Eligibly and Post-Eligibility

Appendix C-1: Eligibility

MEDICAID ELIGIILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. **X** Low-income families with children as described in section 1931 of the Social Security Act.

2. **X** SSI recipients (SSI Rules States and 1634 States).

4. **X** Optional State Supplement recipients

5. **X** Optional categorically needy aged and disabled who have income at (Check one):

   a. **X** 100% of the Federal poverty level (FPL)

6. **X** The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for this special home and community-based waiver group at 42 CFR 435.217.

   a. **X** Yes b. ___ No

   Check one:

   a. **X** The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community.

Appendix C-2: Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435-217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (an periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and needed home and community-based services in order to remain in the community (§435-217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use regular post eligibility rules at 435-726 and 435-735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options with regard to the application of post eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435-726 and §435-735 just as it does for other individuals found eligible under §435-217 or;

OPTION 2: It may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435-726 AND §435-735

The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance or the medically needy standard. The State may choose which standard to apply.

If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC eligibility standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligibly as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance "which is reasonable in amount for clothes and other personal needs of the individual. . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month, but must be a reasonable amount for clothing and other personal needs of an individual while in an institution. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. Therefore, the $30 PNA may not be a reasonable mount when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rule may use as the personal needs allowance the maintenance amount which the State has elected for home and community-based services waiver participants who do not have community spouses.

NOTE: If the State elects to use the institutional PNA, it must demonstrate that this is a reasonable amount to cover the cost of the individual's maintenance needs in the community (see OPTION2).

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **X** **SSI State:** The State is using the post eligibility rules at 42 CFR 435.726. Payments for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

   A. **§435.726** – States which do not use more restrictive eligibility requirements than SSI.

      a. Allowances for the needs of the

1. Individual (check one):

   C. **X** The following formula is used to determine the needs allowance: 300% SSI FBR

Note: If the amount protected from waiver recipients in item 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2. and 3. following.

2. Spouse only (check one):

   G. **X** Not applicable (N/A)

3. Family (check one):

   G. **X** Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

APPENDIX D – ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATON OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

X Physician (M.D. or D.O.)

X Other (specify):

Director of Consumer Assessments: Minimum qualifications are a Master's Degree in Social work or a related field from an accredited college or university; or a Bachelor's degree in Social Work from an accredited college or university; or a Bachelor's degree from an accredited college or university in an unrelated field of study, and at least one year of experience in programs for person with mental retardation or a service coordination program.

Psychologist: Minimum qualification are a Master's degree in psychology plus two years of experience working with persons with lifelong disabilities, or a Master's degree in a health or human service field plus four years experience working with persons with lifelong disabilities.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

X Every 12 months

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

X The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (specify):

X Other (specify):

Service Coordinator or Early Interventionist: Minimum qualifications are a Master's degree in Social Work or related field from an accredited college or university; or a Bachelor's degree in Social Work from an accredited college or university; or a Bachelor's degree from an accredited college or university in an unrelated field of study, and at least one year of experience in programs for persons with mental retardation or a service coordination program.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (check all that apply):

X "Tickler" file

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

   X By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

   X By the Service Coordinator or Early Interventionist

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix (Attachment 1 to Appendix D-3).

For persons diverted rather than Deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

LEVEL OF CARE DETERMINATION FOR ICF/MR

NAME _____ **ID** _____ **DOB** _____

1. Person has: (at least one of the following)

   a) MR: _____Yes _____No

   b) Related Disabilities: _____Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

2. Supervision is necessary due to: (at least one of the following)

   Impaired judgment/limited capabilities _____ Yes _____ No

   Behavior problems _____ Yes _____ No

   Abusiveness _____ Yes _____ No

   Assaultiveness _____ Yes _____ No

   Drug effects/medical monitorship _____ Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

3. Services are needed for: (at least one of the following)

   a) acquisition of behaviors necessary to function with as much self determination and independence as possible _____ Yes _____ No

   b) prevention or deceleration of regression or loss of current optimal functional status. _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

APPROVED FOR ICF/MR LEVEL OF CARE _____ Yes _____ No

_____Initial Determination _____Annual Recertification _____Other (specify)

_____ _____
Signature/Title Date

MR/RD (revised 9/02)

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. Informed of any feasible alternatives under the waiver; and

   b. Given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing (Attachment 1 and 1a to Appendix D-4);

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver (Attachment 2 to Appendix D-4);

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services (Attachment 3 to Appendix D-4); and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E (Attachment 4 to Appendix D-4).

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Copies of the Freedom of Choice documentation form are maintained by the Service Coordinator or Early Interventionist in the individual's file.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MR/RD WAIVER
FREEDOM OF CHOICE

Individual's Name: _____
Address: _____
_____
Phone #: _____
(Please type or print)

This is to certify that the above named individual was informed of the feasible alternatives under the waiver, given the opportunity to choose between institutional and home and community-based services and was informed of the right to request a fair hearing. The individual has selected by written acknowledgment, or by the written acknowledgment of his or her representative, to receive the option marked below.

Signature: _____ Date: _____
Service coordinator/early interventionist

Service coordinator/early interventionist's Name: _____
Address: _____
Phone #: _____
(Please type or print)

I, or my authorized representative, have been afforded an opportunity to make an informed choice of receiving either institutional or home and community-based services. My and/or my representative's signature below indicates that at this time, I have chosen to receive:

☐ **home and community-based services (MR/RD waiver)**
☐ **institutional services (ICF/MR)**

In the event that I have not been informed of feasible options under the waiver or been given the option of institutional or waiver services, I understand that I have the right to request a fair hearing.

Recipient's Signature: _____
Date: _____

Representative's Signature: _____
Date: _____

Representative's Name: _____

Representative's Address and Phone #, if different from Recipient's: _____
_____

MR/RD Form 1 (8/2001) _____

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach a copy of the written reconsideration decision received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

Description of the agency's procedure(s) for informing eligible individuals (or their legal representative) of the feasible alternatives available under the waiver:

As part of the Service Coordinator / Early Interventionist's assessment and service planning visit, individuals and responsible parties are provided with adequate information to make informed decisions. Service planning addresses problems and feasible solutions. It also includes an exploration of all resources utilized by the client, both formal and informal, as well as those waiver services, which may be available to meet the individual's needs and those needs, which cannot be met.

Description of the State's procedures for allowing individuals to choose either institutional or home and community-based services:

Each individual must make a written choice of either institutional or home and community-based services, which will remain in effect until he/she changes his/her choice. The only exception to making a written choice is when the individual is not capable of signing the Freedom of Choice form. In such cases, service(s) are not denied. Instead, the reason for the absence of the **signature of the individual is** carefully documented by the service coordinator **or early interventionist on the Freedom of Choice form and in service note documentation.** A **legal guardian** is sought to assist in arranging for appropriate services. This assistance may include signing the Freedom of Choice form.

For individuals under the age of 18, the Freedom of Choice Form is signed by their legal guardian. If the consumer remains enrolled when they turn 18, the consumer will sign the Freedom of Choice form within 30 days of their eighteenth (18th) birthday. Exceptions regarding signature as noted above apply.

Description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E:

Any waiver applicant or recipient has the right to request a **Reconsideration / Appeal** if not given the choice of home and community-based services as an alternative to institutional services, or if a decision adversely affects his/her eligibility status or receipt of services. **Reconsiderations / Appeals** are conducted by the **South Carolina Department of Disabilities and Special Needs** and the South Carolina Department of Health and Human Services, Division of Appeals and Hearings, **respectively**. Information regarding the individual's right to **request a Reconsideration / Appeal** is printed on the reverse side of **or attached to the initial** Level of Care Certification Letter (Attachment 4a and 4b to Appendix D-4). **In addition, the consumer receives this information when the Freedom of Choice Form is signed (printed on the reverse side or attached to the Freedom of Choice form), with written notification regarding denial, reduction, suspension or termination of a Waiver service(s), and written notification of impending disenrollment from the Waiver.**

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

LEVEL OF CARE

CERTIFICATION LETTER

TO: _____ COUNTY OF RESIDENCE: _____

SS#: _____ MEDICAID #: _____

LOCATION OF ASSESSMENT: _____

The South Carolina Department of Disabilities and Special Needs has evaluated the information submitted by your physician and other professionals and has determined that:

( ) according to Medicaid criteria, you do not meet medical requirements for Intermediate Care for the Mentally retarded. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long term care facility.

( ) according to present Medicaid criteria, you meet requirements to receive long term care at the following level:

( ) Intermediate Care Level for the Mentally Retarded

This letter must be presented to the facility to which you are admitted.

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

If you disagree with this determination, please read the reverse side of this notification.

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

_____

SIGNATURE/TITLE

_____

DATE OF ASSESSMENT

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

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Columbia, SC 29202-8206

The consumer/representative must attach a copy of the written reconsideration decision received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

APPENDIX E – PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

   X Service Coordinator or Early Interventionist

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

   X By Service Coordinator or Early Interventionist

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

   X Every 12 months. **The new plan of care document must be fully completed, approved by the Service Coordinator or Early Interventionist and ready for implementation prior to the 364th date from the previous plan of care.**

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Plans of care are made available to the Medicaid agency anytime during normal working hours. The Medicaid agency will review a representative sample of plans of care on an annual basis by conducting waiver record chart reviews at local Disabilities and Special Needs County Boards. SCDDSN will follow policies and procedures that have been approved by the State Medicaid agency. Any corrective actions found necessary by the State Medicaid agency will be completed by SCDDSN as required by the State Medicaid agency.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care forms to be utilized in this waiver are attached to this Appendix (Attachment 1 and Attachment 2 to Appendix E-2).

SOUTH CAROLINA

DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

SINGLE PLAN

Mental Retardation

Head and Spinal Cord Injury

Autism

January 2003 Version

SINGLE PLAN

I. BACKGROUND DOCUMENT

A. *Identifying Information*

Name:										
Address:										
Phone No.:		Social Security No.:					Date of Birth:			
Medicaid No.:				Medicare No.:						
Other Insurance:										
Primary Contact and Relationship:										
Address:										
Phone No.:										
Emergency Contacts:										
Name:				Phone No.:						
Name:				Phone No.:						
Critical Information:										
Eligibility Category:	□ □ □ □ □	Autism At Risk High Risk MR/RD HASCI	DSN Waiver Information:	□ □ □	MR/RD Waiver HASCI Waiver None					
Which Agency is responsible for this consumer's primary case management?										
ICAP Level:	1 [ ]	2 [ ]	3 [ ]	4 [ ]	5 [ ]	6 [ ]	7 [ ]	8 [ ]	9 [ ]	N/A [ ]
Admission Date (for ICF/MR only): □ N/A										
Plan Implementation Date:										

B. ***Current Life Situation***

General/Personal History/Family Information:
Emergency/Disaster Plan and Back-Up Plan:
Intervention/Services Summary and Assessment Results (informal and formal):
Level of Care (for waiver participants and ICF/MR residents): Type of Last Level of Care Evaluation: □ NF □ ICF/MR □ N/A Effective Date of Last Level of Care Evaluation: _____ Expiration Date of Last Level of Care Evaluation: _____ Results of LOC Evaluation: □ Met □ Not Met Explanation of Results:

All needs included below should be supported by previous assessments or services information.

Needs and Recommendations for Actions:

Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:

C. *Physical Health*

Primary Physician of Choice:				
Address:				
Phone No.:		Hospital of Choice:		
Date of Last Physical:		Date of Last PPD (if applicable):		
Date of last OB/GYN (if female and at least 16 years of age):				
Date of Last Dental Exam:		Date of Last Vision Exam:		
Other Medical Professionals Providing Care (to include address and phone numbers):				
DSM IV/Mental Health Diagnosis:	☐	YES	☐	NO
If yes, explain:				
Behavioral/Emotional Health Issues:	☐	YES	☐	NO
If yes, explain:				

Describe any current medical and emotional/behavioral conditions, treatments, and medications.				
Condition	Medication/Intervention and Frequency	Prescriber/Provider/ Person Responsible	Service Name	Funding Source

What Health Insurance does this person have? [ ] Medicaid [ ] Medicare
[ ] Other: _____

Please indicate which of the following services will likely be needed during the next year and if needed, will be funded by one or all of the insurers noted above (this DOES NOT include Waiver Services):			
[ ]	Hospital/Emergency Room	[ ]	Physician Visits
[ ]	Prescribed Drugs	[ ]	Home Health
[ ]	Durable Medical Equipment	[ ]	Dental (children or emergency)
[ ]	EPSDT	[ ]	Transportation
[ ]	Targeted Case Management	[ ]	Mental Health
[ ]	Family Planning	[ ]	Other:
Note: if services are needed and not covered by insurance, the need must be addressed.			

List any therapies, equipment, assistive devices or supplies currently prescribed:				
Therapy, equipment, assistive devices, or supplies	Schedule for use/Frequency of Services	Provider/Person Responsible	Service Name	Funding Source

Assistance with Medication:				
Needed?	[ ]	Yes	[ ]	No
If yes, describe the level of assistance needed:				
Physical assistance only (open bottle, pour medication, etc.)	[ ]			
Verbal reminders/prompts to take	[ ]			
Both	[ ]			
Any special instructions for medication administration:				

Other Physical/Functional Health				
Significant health issues since last review/to date?				
Does the consumer have any allergies? If yes, explain:	[ ]	Yes	[ ]	No
How does this person communicate?				
Are Interpreter Services needed?	[ ]	Yes	[ ]	No
If yes, explain:				
Diet:				
Special Instructions:				
Has this person received genetics services/counseling:	[ ]	Yes	[ ]	No
If no, does this person wish to receive genetics services/counseling:	[ ]	Yes	[ ]	No
Additional Comments (if applicable):				

<u>All needs included below should be supported by previous assessments or services information</u>.

Physical Health Needs and Recommendations for Actions:

Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:

D. ***Rights Issues***

Is this person a minor (under the age of eighteen)?	[ ]	Yes	[ ]	No	
Has this person been adjudicated incompetent, been appointed a conservator, or relinquished power of attorney?	[ ]	Yes	[ ]	No	
If yes, which one(s)?					
If this person has not been adjudicated incompetent, does he/she receive assistance with decision making/planning?	[ ]	Yes	[ ]	No	[ ] N/A
If yes, who provides the assistance?					
Does this person have a Living Will, Health Care Power of Attorney, Do not Resuscitate Order or EMS Do Not Resuscitate Order?	[ ]	Yes	[ ]	No	
If yes, which one(s):					
If this person is enrolled in a DSN HCBS Waiver, has he/she been notified of his/her right to a choice of qualified providers and right to appeal waiver decisions?	[ ]	Yes	[ ]	No	[ ] N/A
Have any rights issues been reviewed by the Agency's Human Rights Committee on this person's behalf?	[ ]	Yes	[ ]	No	
Any additional rights issues?					

This agency must comply with Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990 and Age Discrimination Act of 1975. This agency has designated the person noted below to coordinate the Agency's complaint process. If you feel you have been discriminated against, please contact this person at the number noted.

Compliance Coordinator's Name _____ Telephone Number _____

General Comments (if applicable):

All needs included below should be supported by previous assessments or services information.

Rights Needs and Recommendations for Actions:

Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:

E. *Financial Resources*

Indicate the financial resources currently being received:	
Earned income from work	[ ]
Medicaid	[ ]
SSI	[ ]
SSDI	[ ]
Social Security Administration	[ ]
Food Stamps	[ ]
Housing Supplements	[ ]
DSN Family Supports	[ ]
Are resources adequate to meet current needs?	[ ] Yes [ ] No
Is this person at risk for losing benefits due to resources or income in excess of program limits?	[ ] Yes [ ] No
NOTE: If this person resides in a SCDDSN sponsored residential option, a Financial Plan must be completed as required by 200-12-DD.	
Additional Comments:	

All needs included below should be supported by previous assessments or services information.

Financial Needs and Recommendations for Actions:

Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:

F. ***Personal Priorities and Preferences***

Would you like a facilitator to assist with planning? [ ] Yes [ ] No [ ] N/A (SCDDSN Regional Centers only)	
If yes, who is your facilitator of choice?	
Who, if anyone, would you like to participate in your planning meeting (include addresses and phone numbers if available)?	
Do you have a preference for where and when your planning meeting is held?	[ ] Yes [ ] No
If yes, where and when:	
Are there specific topics/concerns you wish to discuss during the planning session (and included as a need/recommendation)?	[ ] Yes [ ] No
If yes, explain:	
Are there specific topics/concerns you do **NOT** want to discuss during the planning meeting?	[ ] Yes [ ] No
If yes, explain:	
Have your participated in a "Personal Outcomes Interview" Or any other outcome interview?	[ ] Yes [ ] No
What areas of concern were noted:	
Have these areas been addressed/being addressed?	[ ] Yes [ ] No
If not, would you like to address them during your planning session?	[ ] Yes [ ] No
Are you a registered voter?	[ ] Yes [ ] No [ ] N/A
If no, would you like to be?	[ ] Yes [ ] No
Additional Comments (if applicable):	

All needs included below should be supported by previous assessments or services information.

Personal Preferences Needs and Recommendations for Actions:

Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:

G. Comments: Provide any additional information including needs not previously covered in this document

All needs included below should be supported by previous assessments or services information.

Miscellaneous Needs and Recommendations for Actions:

Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:
Need:	Recommendation to Address Need:

G. Signature

Signature of Person Completing

Date Completed

Printed Name

II. PLANNING DOCUMENT

A. Needs and Recommendations for Actions from the Background Document (must be exactly as written in the Background Document)

Need:
Recommendation:
Discussion (to determine the action(s) needed):
Will this be addressed in this year's Plan of Supports? [ ] Yes [ ] No
If no, explain:

Need:
Recommendation:
Discussion (to determine the action(s) needed):
Will this be addressed in this year's Plan of Supports? [ ] Yes [ ] No
If no, explain:

Need:
Recommendation:
Discussion (to determine the action(s) needed):
Will this be addressed in this year's Plan of Supports? [ ] Yes [ ] No
If no, explain:

B. Needs and Recommendations for Actions that resulted from discussion at the Plan Meeting

Need:
Recommendation:
Discussion (to determine the action(s) needed):
Will this be addressed in this year's Plan of Supports? [ ] Yes [ ] No
If no, explain:

Need:
Recommendation:
Discussion (to determine the action(s) needed):
Will this be addressed in this year's Plan of Supports? [ ] Yes [ ] No
If no, explain:

Need:
Recommendation:
Discussion (to determine the action(s) needed):
Will this be addressed in this year's Plan of Supports? [ ] Yes [ ] No
If no, explain:

III. PLAN OF SUPPORTS

Need:
Action(s):
Funding Source:
Provider:
Timeframe/Projected Completion Date:
Person Responsible:

Need:
Action(s):
Funding Source:
Provider:
Timeframe/Projected Completion Date:
Person Responsible:

Need:
Action(s):
Funding Source:
Provider:
Timeframe/Projected Completion Date:
Person Responsible:

Need:
Action(s):
Funding Source:
Provider:
Timeframe/Projected Completion Date:
Person Responsible:

NOTE: For any Need/Action to be funded using MR/RD Waiver or HASCI Waiver funding, the Waiver Services Summary must be attached.

The contents of this plan were shared with the consumer or his/her legal guardian on the date noted below. He/She acknowledged that the document reflects the decisions reached during the planning meeting.

Plan Manager Signature: _____

NAME (typed/printed): _____

DATE: _____

IV. WAIVER SERVICES SUMMARY

Waiver Service Name:
Provider Name:
Frequency/Duration:
Comments:

Waiver Service Name:
Provider Name:
Frequency/Duration:
Comments:

Waiver Service Name:
Provider Name:
Frequency/Duration:
Comments:

Waiver Service Name:
Provider Name:
Frequency/Duration:
Comments:

PLANNING MEETING ATTENDEES (SIGNATURES)

DATE OF PLANNING MEETING:

Name:
Title/Relationship:

Name:
Title/Relationship:

Name:
Title/Relationship:

Name:
Title/Relationship:

Name:
Title/Relationship:

Name:
Title/Relationship:

Name:
Title/Relationship:

AMENDMENT TO THE PLAN

Consumer's Name:	Date:
What happened to necessitate this change?	
Discussion:	
Need:	
Actions:	
Funding Source:	
Provider:	
Timeframe/Projected Completion Date:	
Person Responsible:	

Signatures:	Date:

SOUTH CAROLINA

DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

FAMILY SERVICE PLAN

(FSP)

SOUTH CAROLINA Department OF Disabilities AND Special Needs

_____'s

Family Service Plan (FSP)
(For Children 3-6 years old) *

Demographic Information

Dear Family,

The development of a Family Service Plan (FSP) is a process in which family members and service providers work together as *partners*.

Together we will create a plan of action to support your family in meeting your child's developmental and educational needs.

1. CHILD INFORMATION		
Full Legal Name:	DOB:	Gender: M F
Race: □ White □ Black □ Hispanic □ Asian/Pacific Islander □ American Indian	Child's SSN:	
Medicaid Number:	Insurance Policy Number	
2. PRIMARY CAREGIVER		
Name:	Relationship to Child:	
Home Phone:	Other Phone:	
Best Place to Be Reached:	Best Time:	
Home Address:		
Directions to Home:		
Primary Language:	Interpreter Needed? Yes No	
3. EARLY INTERVENTIONIST/SPECIAL INSTRUCTOR		
Early Interventionist/Special Instructor	Agency:	
Address:	Phone:	
4. MEDICAL HOME		
Primary Medical Provider:	Phone:	
Address:		
5. FSP TRACKING		
FSP	Given Sent to Parent	Sent to Medical Home
Annual: / /	/ /	/ /
Effective Date for Initial FSP:		

FSP Date: _____ Child's Name: _____

Family's Priorities

Did your child have a significant birth? What has your child's medical history been like? What, if any, are your child's diagnosis? How has any of the above affected the child's and families' routines and activities?	**6. Significant birth, development/medical history, and/or diagnosis and how this history effects their routines, activities, and places.**

FSP Date: _____ Child's Name: _____

Description of Child

Please describe what your child is doing and what you would like to see him or her doing in each of the following areas.

- **Understanding and communicating** (receptive and expressive language) i.e., startle at loud noises, point to desired objects, use two or more word sentences.
- **Doing things for himself or herself** (adaptive development) i.e., help hold a bottle, reach for a toy, and help dressing.
- **Movement and coordination** (gross and fine motor development) i.e., reach for and play with toes, sit and roll, throw a small ball, thread cord through large beads.
- **Getting along with others** (social and emotional development) i.e., smile and coo, pull on your hand or clothes to gain attention, share a toy or take turns with others.
- **Thinking and learning** (cognitive development) i.e., look for dropped toy, pull toy on a string, do a simple puzzle.
- **Are there any resources in the community that would be helpful to you and your family? What?**

7. CHILD STRENGTHS/NEEDS IDENTIFIED BY FAMILY

What is your child doing now? Describe your child's most enjoyable toys, games, activities, and events.

8. FAMILY RESOURCES, PRIORITIES AND CONCERNS

Are there any supports/resources in the community that would be helpful to your family, at this time. Include any ongoing service provided to your child and family?

FSP Date: _____ Child's Name: _____

Assessment Information

9. TEAM ASSESSMENT			
Health	Last Physical Exam:	Immunization Status:	
	Allergies:	Recent Hospitalizations:	
Comments:			
Hearing	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Comments:			
Vision	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Comments:			
Adaptive (feeding, eating, dressing, sleeping)	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:		Needs:	

Team Assessment Continued			
Cognitive (learning and thinking)	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Communication (making and understanding sounds, using gestures and words)	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Fine Motor (using hands and fingers)	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:			Needs:

Team Assessment Continued			
Gross Motor (moving, crawling, sitting, using large muscles)	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Social and Emotional (interacting with others)	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Other:	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
	Date of Assessment:	Instrument:	
	CA:	AA:	Assessor:
Strengths:			Needs:

10. ONGOING ELIGIBILITY

DDSN Eligibility Category

☐ Mental Retardation/Related Disability ☐ High-Risk ☐ Autism
☐ HASCI ☐ At-Risk Re-evaluation date: _____
☐ DDSN Eligibility pending

FSP Date: _____ Child's Name: _____

Things to Be Done

The FSP team will develop outcomes and strategies for your child and family. Each major outcome will be written on a separate page.

11. OUTCOMES (Add additional pages as needed)	
Major Outcome#: ____ (What do we want to accomplish and how well we know when it is achieved?)	Target Date:
	Six Month Review (ongoing, modified, terminated) Circle one.
	Date Met:
What are the ways the people in the child's life can support the accomplishment of this outcome? What are the learning opportunities and activities that build on the child's and family's interests and abilities to support this outcome?	
What, if any, services, are needed to support the people in the child's life in achieving this outcome? List the Natural Environment(s) in which the service may be provided.	

FSP Date: _____ Child's Name: _____

Other Services

12. Services		
Service	**Provider**	**Funding Source and Amount, Frequency, and Duration**

FSP Date: _____ Child's Name: _____

Signatures

Signature	**Role**	**Agency** (if applicable)	**Date**
	Parent/Guardian		
	Parent/Guardian		
	EI/Special Instructor		

Facilitation:
I was offered the choice of a facilitated plan. Parent/Caregiver's initials _____

Provider Choice:
I was offered a choice of providers. Parent/Caregiver's initials _____

INDIVIDUALIZED FAMILY SERVICE PLAN

IFSP

BabyNet
South Carolina's Early Intervention System
SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

_____'s
Individualized Family Service Plan
(IFSP)

Dear Family,

The development of an Individualized Family Service Plan (IFSP) is a process in which family members and service providers work together as *partners*.

Together we will create a plan of action to support your family in meeting your child's developmental and educational needs.

Demographic Information

1. CHILD INFORMATION

Legal Last Name: First Name:	DOB:	Gender: M F
Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian	Child's SSN:	

2. PARENT

Name:	Relationship to Child:
Home Phone:	Other Phone:
Best Place to Be Reached:	Best Time:
Home Address:	
Directions to Home	
Primary Language:	Interpreter Needed? Yes No / Active Military? Yes No

3. SURROGATE PARENT

Is there a need for a surrogate parent? Yes No	Surrogate Address
Surrogate Name:	
Surrogate Phone:	Date of Surrogate Appointment:

4. SERVICE COORDINATION

BN Service Coordinator:	Agency:
Address:	Phone:

5. MEDICAL HOME

Primary Medical Provider:	Phone:
Address:	

6. IFSP TRACKING

IFSP	Given/Sent to Parent	Sent to BN	Sent to Medical Home
Initial:	/ /	/ /	/ /
Annual:	/ /	/ /	/ /

Please describe what your child is doing and what you would like to see him or her doing in each of the following areas.

- **Understanding and communicating** (receptive and expressive language) i.e., startle at loud noises, point to desired objects, use two or more word sentences.
- **Doing things for himself or herself** (adaptive development) i.e., help hold a bottle, reach for a toy, and help dressing.
- **Movement and coordination** (gross and fine motor development) i.e., reach for and play with toes, sit and roll, throw a small ball, thread cord through large beads.
- **Getting along with others** (social and emotional development) i.e., smile and coo, pull on your hand or clothes to gain attention, share a toy or take turns with others.

Thinking and learning (cognitive development) i.e., look for dropped toy, pull toy on a string, do a simple puzzle. Consider your family's every day routines and activities. Think about where your child spends time. Are there places that other children spend time that you would like for your child to spend more time?

Description of Child

7. CHILD STRENGTHS/NEEDS IDENTIFIED

What is your child doing now? Describe your child's most enjoyable toys, games, activities, events

What do you hope to see your child do, or do better?

8. EVERYDAY ROUTINES, ACTIVITIES, AND PLACES

What are your child's daily routines and activities? Where do they take place? Who usually spends time with him or her? How often/how much time? Include day/evening/weekend and frequency

IFSP DATE: _____ Child's Name: _____

Your family's strengths, needs and resources are important influences on your child's learning and development.

The following categories may guide your thinking as you respond to the questions in the box.

- **Physical** (food, shelter, transportation, etc.)
- **Financial** (income, bills, etc.)
- **Health** (medical, safety, immunization, etc.)
- **Guidance** (discipline, parenting, etc.)
- **Emotional** (nurturing, love, companionship, etc.)
- **Recreation** (free time, activities, sports, etc.)
- **Community Supports** (Faith-based, support groups, neighbors, relatives etc.)

You may share as much or as little family information as you choose.

Family's Priorities

9. FAMILY RESOURCES, PRIORITIES AND CONCERNS

NOTE: This section is voluntary on behalf of family! Your child can still receive services if you do not complete this section and your child is eligible.

My family does not wish to participate in this section	Family Initials Here

Family Assessment Instrument or Process Used:

What people, places and things are (or could be) supportive and helpful to your family and child? (Resources)

What things are most important or of most concern to you and your family?

IFSP Date: _____ Child's Name: _____

Assessment Information			
10. TEAM ASSESSMENT			
Health	Last Physical Exam:	Immunization Status:	
	Allergies:	Recent Hospitalizations:	
Strengths:		Needs	
Hearing	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:		Needs:	
Vision	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:		Needs	
Adaptive (feeding, eating, dressing, sleeping)	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:		Needs:	

Team Assessment Continued			
Cognitive (learning and thinking)	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Communication (making and understanding sounds, using gestures and words)	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Fine Motor (using hands and fingers)	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:			Needs:

IFSP Date: _____ Child's Name: _____

Team Assessment Continued

Gross Motor (moving, crawling, sitting, using large muscles)	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Social and Emotional (interacting with others)	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:			Needs:
Other:	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
	Date of Assmt:	Instrument & Score:	
	CA:	AA:	Assessor:
Strengths:			Needs:

11. ONGOING ELIGIBILITY

□ Child is eligible based upon current developmental delay (see assessment results above).

□ Child is no longer eligible for BabyNet services.

IFSP Date: _____ Child's Name: _____

Things to Be Done

The IFSP team will develop outcomes and strategies for your child and family. The starting place is the information you provided in section 7 on page 2 regarding what you hope to see your child do or do better. Each major outcome will be written on a separate page.

12. OUTCOMES (Add additional pages as needed)			
Major Outcome #: _____ (What do we want to accomplish?) How will we know when the outcome is achieved?			Target Date: Date Achieved: :
Review OAS:	Date:	Annual OAS:	Date:

Outcome Attainment Scale (OAS): 1. Situation changes, no longer a need, 2. Situation changed, still a need, 3. Intervention started, still a need, 4. Outcome partially attained or accomplished but not to team's satisfaction, 5. Outcome attained or accomplished but not to a team's satisfaction, 6. Outcome mostly attained or accomplished to team's satisfaction, 7. Outcome attained or accomplished to the team's satisfaction.

NATURAL SUPPORTS:
What are the ways the people in the child's life can support the accomplishment of this outcome? What are the learning opportunities and activities that build on the child's and family's interests and abilities to support this outcome? (Refer to section 8 on page 2)

BABYNET SUPPORTS:
What, if any, BN services, either consultative or direct, are needed to support the people in the child's life in achieving this outcome? *List the Natural Environment(s) in which the service should be provided.

*If the IFSP team determines that the outcome cannot be accomplished in the Natural Environment(s) listed for the child, Section A of the Justification for Services in "Other Than Natural Environments" form must be completed by the IFSP team and attached.

IFSP Date: _____ Child's Name: _____

Transition Plan

This form must be begun by the IFSP team no later than the Annual IFSP Meeting closest to the child's second birthday

13. TRANSITION				
Transition Steps			**Person(s) Responsible**	**Date Completed**
PLANNING				
A. Discuss and educate parents on future placements, what "transition" from the BabyNet System means and what we can do to plan for this transition.				
B. Explore preschool special education services as well as other community program options for your child, including: eligibility for the program, the latest date a referral may be made to the program to ensure there isn't a gap in services, and who to contact for additional information. .				
C. Steps to help your child adjust to and function in a new setting including helping the child to begin to learn new skills needed to get along better in new place(s) (see outcome(s) # ____ _____ _____).				
NOTICE				
D. As part of the **local school district's** child find efforts, your child's name, address, phone number and birthdate will be sent to the _____ school district, using the **School District Child Find Notification Form**, no later than _____ unless you disagree.				
I do not want this information to be sent.	Parent Initials:	Date:		
REFFERAL				
E. Date your child will be referred to the local school district _____				
I do not wish to participate in a Transition Meeting.	Parent Initials:	Date:		
F. If not declined in **E**, complete **Transition Referral form**. Use the **BN Consent to Release/Obtain Information** form to obtain parent's permission to send information to potential future provider(s) or program(s). Date information will be sent by: _____				
MEETING				
G. Unless declined below, schedule Transition Meeting with parent(s), BN Service Coordinator and someone from the potential program(s) to plan home the child is going to make the transition. Meeting must be held no later than: _____				
I do not wish to participate in a Transition Meeting.	Parent Initials:	Date:		
H Additional Steps:				

IFSP Date: ________________________ Child's Name: ________________________

Summary of BabyNet Services

14. BABYNET SERVICES – For services where the location code is not COM, FCC, HOM, or PTC (Natural Environments), Section B of the Justification for Services in "Other Than Natural Environments" form must be completed and attached.

BN Service Code :	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
BN Service Code:	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
BN Service Code:	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
BN Service Code:	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
BN Service Code:	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
BN Service Code:	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
BN Service Code:	Service Description:			Outcome #(s) to Address:		
Start Date:	End Date:	Duration of Each Visit: Minutes:		Primary Method Code:	Fund Code(s):	
Number of Visits: ☐ Week ☐ Every Other Month ☐ Month ☐ Quarterly			Primary Location Code:	Natural Environments Justification Required?	YES	NO
Use codes listed in the BabyNet Service/Payment Guide Section 5.00.00 procedure 5.60.00 to complete this page of the IFSP.						

Other Services and Signatures

15. OTHER SERVICES (Needed, but not paid by BabyNet)

Service	Provider	Funding Sources or Steps to Be Taken to Secure Services

16. CONSENT/TEAM SIGNATURES

Accepting BabyNet Part C Services Recommended by the IFSP Team

I have received a copy of the family rights under Part C of IDEA (*Notice of Child and Family Rights in the BabyNet System*) and these have been explained to me along with this IFSP. I participated in the development of this IFSP and I give informed consent for BabyNet to carry out the activity/activities listed on this IFSP. I have been informed about the activity/activities for which consent is being sought in my native language or other mode of communication. I understand that this consent is voluntary and may be revoked in writing at any time. In addition, I understand that I may decline a service or services without jeopardizing any other BabyNet service(s) my child or family receives. I understand that my IFSP will be shared among the BabyNet System and service providers implementing this IFSP.

Signature of Parent(s):	Date:

IFSP Team Members

Method Codes: A = Attended, S = Speakerphone, E = Written Evaluation Only (not for ongoing service providers)

Signature	Role	Agency (if applicable)	Method Code	Date
	Parent			
	Parent			
	BN Service Coord.			

BabyNet Services are provided to eligible children and their families in compliance with Part C of the individuals with Disabilities Education Act (IDEA).

APPENDIX F – AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   X Payments for all waiver and other State plan service will be made through an approved Medicaid Management Information System (MMIS).

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

   X Yes ___ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   X All claims are processed through an approved MMIS.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

   X The Medicaid agency will make payments directly to providers of waiver services.

   X Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

   The South Carolina Department of Disabilities and Special Needs

   Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

   The Medicaid agency will make payments to providers of waiver services through an approved MMIS.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G – 1

COMPOSITE OVERVIEW

COST – NEUTRALITY FORMULA

Level of Care: ICF/MR

FACTOR	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
C	**5,200**	**5,400**	**5,600**	**5,800**	**6,000**
D	**$34,713**	**$34,713**	**$35,360**	**$36,050**	**$36,209**
D'	**$7,211**	**$7,355**	**$7,502**	**$7,652**	**$7,805**
G	**$98,181**	**$100,144**	**$102,148**	**$104,190**	**$106,274**
G'	**$1,890**	**$1,928**	**$1,966**	**$2,006**	**$2,046**

UNDUPLICATED INDIVIDUALS:

YEAR 1 of RENEWAL **5,200**

YEAR 2 of RENEWAL **5,400**

YEAR 3 of RENEWAL **5,600**

YEAR 4 of RENEWAL **5,800**

YEAR 5 of RENEWAL **6,000**

Factor C is computed as follows:

X The State will make waiver services available to individuals in the target group up to lesser of the number of individuals indicated as Factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit, which is less than Factor C for that waiver year.

APPENDIX G – 2

Factor D LOC: **ICF/MR**

Demonstration of Factor D estimates: Waiver Year 1

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	52	22	$40.00/Hour	$45,760
OT	52	22	40.00/Hour	45,760
Speech	52	33	40.00/Hour	68,640
Psychological services	26	33	66.00/Hour	56,628
Audiology	52	11	40.00/Hour	22,880
Behavior Supports	52	33	60.00/Hour	102,960
Special Equip./Supplies	1,248	N/A	2,500.00/Per Item	3,120,000
Day Hab.	1,872	198	42.00/Day	15,567,552
Prevocational Hab.	2,080	198	42.00/Day	17,297,280
Supported Employment	312	88	20.43/Hour	560,926
Residential Hab.-Daily	2,704	319	150.00/Day	129,386,400
Residential Hab.-Hourly	52	176	16.50/Hour	151,008
Adult Day Health	26	198	38.00/Day	195,624
Personal Care 1	52	440	10.05/Hour	229,944
Personal Care 2	520	550	12.80/Hour	3,660,800
Prescription Drugs	2,288	22	36.75/Per Item	1,849,848
Environmental Mods.	78	N/A	7,500.00/Per Item	585,000
Respite Non-Inst. Day	572	27.5	50.00/Day	786,500
Respite Non-Inst. Hour	208	330	6.25/Hour	429,000
Respite Inst. ICF/MR	26	22	148.23/Day	84,788
Adult Companion	104	440	10.80/Hour	494,208
Adult Dental	832	2	102.00/Per Visit	169,728
Adult Vision	572	2	70.00/Per Visit	80,080
Nursing LPN	182	1,320	20.00/Hour	4,804,800
Nursing RN	26	660	30.00/Hour	514,800
Private Vehicle	26	N/A	7,500.00/Per Item	195,000
Grand Total (sum of Column E):				**$180,505,914**
Factor C:				**5,200**
Factor D (Per Capita Average): Divide by C:				**$34,713**
Average Length of Stay:				**11.00 months**

APPENDIX G – 2

Factor D LOC: **ICF/MR**

Demonstration of Factor D estimates: Waiver Year 2

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	54	22	40.00.Hour	$47,520
OT	54	22	40.00/Hour	47,520
Speech	54	33	40.00/Hour	71,280
Psychological services	27	33	66.00/Hour	58,806
Audiology	54	11	40.00/Hour	23,760
Behavior Supports	54	33	60.00/Hour	106,920
Special Equip./Supplies	1296	N/A	2,500.00/Per Item	3,240,000
Day Hab.	1,944	198	42.00/Day	16,166,304
Prevocational Hab.	2,160	198	42.00/Day	17,962,560
Supported Employment	324	88	20.43/Hour	582,500
Residential Hab.-Daily	2,808	319	150.00/Day	134,362,800
Residential Hab.-Hourly	54	176	16.50/Hour	156,816
Adult Day Health	27	198	38.00/Day	203,148
Personal Care 1	54	440	10.05/Hour	238,788
Personal Care 2	540	550	12.80/Hour	3,801,600
Prescription Drugs	2,376	22	36.75/Per Item	1,920,996
Environmental Mods.	81	N/A	7,500.00/Per Item	607,500
Respite Non-Inst. Day	594	27.5	50.00/Day	816,750
Respite Non-Inst. Hour	216	330	6.25/Hour	445,500
Respite Inst. ICF/MR	27	22	148.23/Day	88,049
Adult Companion	108	440	10.80/Hour	513,216
Adult Dental	864	2	102.00/Per Visit	176,256
Adult Vision	594	2	70.00/Per Visit	83,160
Nursing LPN	189	1,320	20.00/Hour	4,989,600
Nursing RN	27	660	30.00/Hour	534,600
Private Vehicle	27	N/A	7,500.00/Per Item	202,500
Grand Total (sum of Column E):				**$187,448,449**
Factor C:				**5,400**
Factor D (Per Capita Average): Divide by C:				**$34,713**
Average Length of Stay:				**11.00 months**

APPENDIX G – 2

Factor D LOC: **ICF/MR**

Demonstration of Factor D estimates: Waiver Year 3

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	56	22	40.00.Hour	49,280
OT	56	22	40.00/Hour	49,280
Speech	56	33	40.00/Hour	73,920
Psychological services	28	33	66.00/Hour	60,984
Audiology	56	11	40.00/Hour	24,640
Behavior Supports	56	33	60.00/Hour	110,880
Special Equip./Supplies	1,344	N/A	2,500.00/Per Item	3,360,000
Day Hab.	2,016	198	42.84/Day	17,100,357
Prevocational Hab.	2,240	198	42.84/Day	19,000,397
Supported Employment	336	88	20.84Hour	616,197
Residential Hab.-Daily	2,912	319	153.00/Day	142,125,984
Residential Hab.-Hourly	56	176	16.83/Hour	165,876
Adult Day Health	28	198	38.00/Day	210,672
Personal Care 1	56	440	10.25/Hour	252,560
Personal Care 2	560	550	13.06/Hour	4,022,480
Prescription Drugs	2,464	22	36.75/Per Item	1,992,144
Environmental Mods.	84	N/A	7,500.00/Per Item	630,000
Respite Non-Inst. Day	616	27.5	51.00/Day	863,940
Respite Non-Inst. Hour	224	330	6.38/Hour	471,610
Respite Inst. ICF/MR	28	22	151.19/Day	93,133
Adult Companion	112	440	10.80/Hour	532,224
Adult Dental	896	2	102.00/Per Visit	182,784
Adult Vision	616	2	70.00/Per Visit	86,240
Nursing LPN	196	1,320	20.00/Hour	5,174,400
Nursing RN	28	660	30.00/Hour	554,400
Private Vehicle	28	N/A	7,500.00/Per Item	210,000
Grand Total (sum of Column E):				**$198,014,382**
Factor C:				**5,600**
Factor D (Per Capita Average): Divide by C:				**$35,360**
Average Length of Stay:				**11.00 months**

APPENDIX G – 2

Factor D LOC: **ICF/MR**

Demonstration of Factor D estimates: Waiver Year 4

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	58	22	42.00.Hour	$53,592
OT	58	22	42.00/Hour	53,592
Speech	58	33	42.00/Hour	80,388
Psychological services	29	33	69.30/Hour	66,320
Audiology	58	11	42.00/Hour	26,796
Behavior Supports	58	33	63.00/Hour	120,582
Special Equip./Supplies	1,392	N/A	2,500.00/Per Item	3,480,000
Day Hab.	2,088	198	43.70/Day	18,066,629
Prevocational Hab.	2,320	198	43.70/Day	20,074,032
Supported Employment	348	88	21.26/Hour	651,066
Residential Hab.-Daily	3,016	319	156.06/Day	150,145,950
Residential Hab.-Hourly	58	176	17.17/Hour	175,271
Adult Day Health	29	198	39.90/Day	229,106
Personal Care 1	58	440	10.46/Hour	266,939
Personal Care 2	580	550	13.32/Hour	4,249,080
Prescription Drugs	2,552	22	38.59/Per Item	2,166,597
Environmental Mods.	87	N/A	7,500.00/Per Item	652,500
Respite Non-Inst. Day	638	27.5	52.02/Day	912,691
Respite Non-Inst. Hour	232	330	6.50/Hour	497,640
Respite Inst. ICF/MR	29	22	154.22/Day	98,392
Adult Companion	116	440	11.34/Hour	578,794
Adult Dental	928	2	107.10/Per Visit	198,778
Adult Vision	638	2	73.50/Per Visit	93,786
Nursing LPN	203	1,320	20.00/Hour	5,359,200
Nursing RN	29	660	30.00/Hour	574,200
Private Vehicle	29	N/A	7,500.00/Per Item	217,500
Grand Total (sum of Column E):				**$209,089,421**
Factor C:				**5,800**
Factor D (Per Capita Average): Divide by C:				**$36,050**
Average Length of Stay:				**11.00 months**

APPENDIX G – 2

Factor D LOC: **ICF/MR**

Demonstration of Factor D estimates: Waiver Year 5

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	60	22	$44.10.Hour	$58,212
OT	60	22	44.10/Hour	58,212
Speech	60	33	44.10/Hour	87,318
Psychological services	30	33	72.77/Hour	72,042
Audiology	60	11	44.10/Hour	29,106
Behavior Supports	60	33	66.15/Hour	130,977
Special Equip./Supplies	1,440	N/A	2,500.00/Per Item	3,600,000
Day Hab.	2,160	198	44.57/Day	19,061,698
Prevocational Hab.	2,400	198	44.57/Day	21,179,664
Supported Employment	360	88	21.68/Hour	686,822
Residential Hab.-Daily	3,120	319	159.18/Day	158,428,670
Residential Hab.-Hourly	60	176	17.51/Hour	184,906
Adult Day Health	30	198	41.90/Day	248,886
Personal Care 1	60	440	10.67/Hour	281,688
Personal Care 2	600	550	13.58/Hour	4,481,400
Prescription Drugs	2,640	22	40.52/Per Item	2,353,402
Environmental Mods.	90	N/A	7,500.00/Per Item	675,000
Respite Non-Inst. Day	660	27.5	53.06/Day	963,039
Respite Non-Inst. Hour	240	330	6.63/Hour	525,096
Respite Inst. ICF/MR	30	22	157.30/Day	103,818
Adult Companion	120	440	11.91/Hour	628,848
Adult Dental	960	2	112.46/Per Visit	215,923
Adult Vision	660	2	77.18/Per Visit	101,878
Nursing LPN	210	1,320	20.00/Hour	5,544,000
Nursing RN	30	660	30.00/Hour	594,000
Private Vehicle	30	N/A	7,500.00/Per Item	225,000
Grand Total (sum of Column E):				**$217,252,605**
Factor C:				**6,000**
Factor D (Per Capita Average): Divide by C:				**$36,209**
Average Length of Stay:				**11.00 months**

APPENDIX G – 3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

1. Residential Habilitation

2. Institutional - ICF/MR Respite

*Note: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Day or hourly based Non-institutional Respite Care.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Continual monitorship of financial data is maintained to assure that room and board costs are excluded from reimbursement.

APPENDIX G – 4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER.

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

APPENDIX G – 5

FACTOR D’ LOC: **ICF/MR**

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of Factor D’. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its cots under Factor D. Do not duplicate these costs in your calculations of Factor D'.

Factor D' is computed as follows:

X Based on CMS Form 372 for years **2001-2002** of waiver **#0237.90**.

APPENDIX G – 6

FACTOR G LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, ICF/MR care that would have been incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for levels of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

X Based on trends shown by CMS Form 372 for years **2001-2002** of waiver **#0237.90** which reflect costs for an institutionalized population at this LOC.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in our calculation of Factor G.

APPENDIX G – 7

FACTOR G' LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for all individuals served in the waiver, were the waiver not granted."

Include in Factor G' the following:

> "The cost of all State Plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day if institutional services."

If institutional respite care is provided as a service under this waiver, calculate its cost under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows:

X Other (specify): Based on CMS Form 372 Report for years **2001-2002** for waiver **#0237.90**.

AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

YEAR 1:	**$1,890 X 1.00 = $1,890**
YEAR 2:	**$1,890 X 1.02 = $1,928**
YEAR 3:	**$1,928 X 1.02 = $1,966**
YEAR 4:	**$1,966 X 1.02 = $2,006**
YEAR 5:	**$2,006 X 1.02 = $2,046**

APPENDIX G – 8

DEMONSTRATION OF COST NEUTRALITY

LOC: **ICF/MR**

YEAR 1	FACTOR D:	**$34,713**	FACTOR G:	**$98,181**
	FACTOR D':	**$7,211**	FACTOR G':	**$1,890**
	TOTAL:	**$41,924**	TOTAL	**$100,071**
YEAR 2	FACTOR D:	**$34,713**	FACTOR G:	**$100,144**
	FACTOR D':	**$7,355**	FACTOR G':	**$1,928**
	TOTAL:	**$42,068**	TOTAL	**$102,072**
YEAR 3	FACTOR D:	**$35,360**	FACTOR G:	**$102,148**
	FACTOR D':	**$7,502**	FACTOR G':	**$1,966**
	TOTAL:	**$42,862**	TOTAL	**$104,114**
YEAR 4	FACTOR D:	**$36,050**	FACTOR G:	**$104,190**
	FACTOR D':	**$7,652**	FACTOR G':	**$2,006**
	TOTAL:	**$43,702**	TOTAL	**$106,196**
YEAR 5	FACTOR D:	**$36,209**	FACTOR G:	**$106,274**
	FACTOR D':	**$7,805**	FACTOR G':	**$2,046**
	TOTAL:	**$44,014**	TOTAL	**$108,320**